Violence in Times of Peace: How Trauma Perpetuates Family Violence in Post-Conflict Environments

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Post-conflict regions have the highest rates of domestic family violence (DFV). While there are several root causes of DFV, conflict is an exacerbating factor for a few reasons. This paper hypothesizes that untreated trauma in ex-combatants contributes to the rise in DFV post-conflict in two main ways. First, untreated trauma and post-traumatic stress disorder (PTSD) cause ex-combatants to recognize and respond aggressively to nonthreatening situations, as explained by the Cycle of Violence Theory. Second, untreated trauma and challenges to gender norms cause ex-combatants to overcompensate with aggression, as explained by the Gender Roles theory. To test this hypothesis, a literature review will study rates of PTSD and DFV in post-conflict regions. Two case studies will be used to evaluate trends. Finally, based on the literature review and case studies, evidence-based recommendations will be identified to address mental health needs of ex-combatants.

Table of Contents

Preface

The thesis, "Violence in Times of Peace," has been written to fulfill the graduation requirements of the University of Pittsburgh's Graduate School of Public Health and for the Peace Corps Coverdell Fellowship. The research question was formulated together with Dr. Martha Terry of the Behavioral and Community Health Sciences program. I would like to acknowledge and thank the three readers of this thesis: Professor Van Nostrand for her thoughtful edits from an extensive health policy and legal background; Dr. Finkel for her perspective on applying a gendered analysis and for always encouraging students to reach past their potential; and Dr. Terry for her critical analysis and for caring so deeply about her students. Working with you will undoubtedly be among my fondest memories of graduate school. I will always be grateful that I had the opportunity to work with and learn from such profoundly talented women.

1.0 Introduction

The end of civil conflict does not mean an end to violence for women and children. In fact, women and children in post-conflict environments experience disproportionately high rates of domestic family violence (DFV). This trend is documented in several post-conflict regions. In Liberia, women living in districts that experienced conflict related fatalities were twice as likely to be a victim of intimate partner violence (IPV) than women living in districts that did not see conflict related fatalities (Kelly et al., 2018). According to the World Bank, the Boko Haram insurgency quadrupled women's risk of experiencing IPV (Ekhator-Mobayode, 2020). UN Women (2013) listed dozens of countries with similar trends, from Afghanistan to Nicaragua. However, in post-conflict settings, peace building efforts continue to focus on preventing public sphere violence from reoccurring, not on the increasing rates of violence being perpetrated in the home. It is important to note that DFV and other forms of violence against women (VAW) [1] are not created by conflict, but rather they are exacerbated by conflict.

In post-conflict regions, rates of Post-Traumatic Stress Disorder (PTSD) and depression post-conflict are above the average global burden while access to mental health services is extremely limited or nonexistent. Peace building efforts in post-conflict environments rarely have the time or budget to service the widespread mental illness. Instead, they focus on rebuilding infrastructure and providing job training. This paper explores how unresolved mental illness in ex-

[1] The author chose to focus on DFV because it encompasses the broadest range of violence. IPV is used to describe violence between partners, which could include romantic partners, married or unmarried, cohabiting or not. VAW is specific for gendered violence that is committed against women. DFV includes violence committed among intimate partners in addition to violence committed against other family members and encompasses violence committed against all genders.

combatants contributes to DFV perpetration post-conflict and identifies opportunities for intervention. While DFV is a complex issue that cannot be solved with one intervention, this paper will focus on treatment of mental illness in ex-combatants as a way to prevent the increase of DFV post-conflict. Specifically, it focuses on a type of Narrative Exposure Therapy (NET) for ex-combatants that has been proven to reduce symptoms of PTSD and help with reintegration into society.

The paper begins with a literature review on the topics of PTSD and depression, DFV, DFV in post-conflict settings, and post-conflict stabilization. The third chapter of the paper will discuss two case studies: Liberia and Peru. These countries were selected because they both experienced years of internal conflict and applied different peace building approaches post-conflict. The fourth chapter will discuss policy and program recommendations to address mental health in post-conflict environments, predominately focusing on NET. The final chapter will discuss limitations of the paper and conclude with a brief piece on the importance and urgency of addressing the issue of mental health and DFV perpetration post-conflict.

2.0 Literature Review and Background

This section provides an overview of research that has been conducted on the topics of DFV and mental health both globally and specifically in post-conflict environments. The first section will discuss mental health diagnoses, PTSD, and depression. The second section will discuss DFV. The third section will relate ex-combatant trauma to perpetration of DFV. Finally, the last section will discuss common post-conflict stabilization programs.

2.1 Post-Traumatic Stress Disorder and Depression

PTSD is a psychiatric condition that some people develop after experiencing or witnessing a terrifying or life threatening event. It is most commonly studied in war veterans, survivors of sexual assault, and survivors of accidents or natural disasters. PTSD is characterized by four main categories of symptoms: 1) intrustion; 2) avoidance; 3) alterations in cognition and mood; and 4) alterations in arousal and reactivity (American Psychiatric Association [APA], 2020). Intrusion includes repeated, involuntary thoughts, dreams, or flashbacks of the traumatic event. Avoidance includes avoiding people, places, and situations that may trigger reminders of the event. People may also avoid thinking or talking about the event. Alterations in cognition includes difficulty remembering aspects of the traumatic event. Alterations in mood includes emotional numbness. Finally, the fourth category of symptoms, alterations in arousal and activity, includes irritability, being easily startled, and difficulty concentrating.

It is common for people without PTSD to experience these symptoms in the days following a traumatic event. However, a PTSD diagnosis occurs when the symptoms persist for at least a month. Symptoms may begin shortly after the traumatic event, or they may begin months after and persist for years. Several therapies to treat symptoms of PTSD exist today. They are used to help the individual process the traumatic event so that it is less triggering and intrusive to everyday life. While symptoms may never permanently go away, beginning therapy soon after the traumatic event yields the best results for long-term reduction of symptoms (ADAA, 2020).

Situational depression is a stress-related form of depression that occurs after a traumatic event or experience (Cirino, 2018). Common symptoms include avoiding social situations, anxiety, trouble concentrating, and lack of enjoyment of normal activities (Cirino, 2018). Recommended treatment for situational depression is psychotherapy to help patients cope with the traumatic event. Failure to treat PTSD and situational depression can cause symptoms to worsen and persist. Untreated PTSD and situational depression can also contribute to unhealthy coping mechanisms such as alcohol or drug abuse.

2.1.1 Mental Health Post-Conflict

Measuring the global burden of mental health disorders, including PTSD and situational depression, is difficult because clinical measures have not been adapted to fit different cultures. This is especially true for countries that have limited funding for mental health services and infrastructure. Because of this, literature on global burden and prevalence is limited. The World Health Organization (WHO) completed a systematic review and meta-analysis of articles published between 2010 and 2017 to study the prevalence of mental health disorders in conflict settings. This study is the most recent measure of the global prevalence of mental health issues in

conflict regions. It includes an analysis of the following mental health disorders: depression, anxiety, PTSD, bipolar disorder, and schizophrenia (Charlson et al., 2019). They found that the prevalence of these mental health disorders was 22.1% in conflict zones. The prevalence for depression was 15.3%, for PTSD was 10.8% and for anxiety disorders was 21.7% (Charlson et al., 2019). The authors report that these numbers are higher than the global burden outside of conflict zones. While lifetime prevalence of mental illness is challenging to quantify, one study the lifetime prevalence of PTSD to range between 1.3% to 8.8% (Atwoli et al., 2015). WHO also looked at mental health disorder by level of severity and found that at any given time during a conflict, 9% of the population had moderate to severe mental health disorders (Charlson et al., 2019). Finally, mean prevalence for multiple diagnoses of mild forms of depression, anxiety, and PTSD was 13% (Charlson et al., 2019).

Although not covered in the WHO systematic review, substance abuse/dependence is a common comorbidity of depression and PTSD (Maedl et al., 2010). In their study of Somali ex-combatants, Maedl et al. (2010) found that those with PTSD used drugs to help forget events of the war, khat shrub in particular, more often than those without PTSD. Khat shrub is a plant that contains a stimulant and can cause feelings of euphoria, making it a popular choice for ex-combatants to use as a form of self-medication. However, it can also cause psychosis and aggravate symptoms of mental illness (Maedl et al., 2010). In other countries, alcohol abuse is a common comorbidity of mental health symptoms. When abused, alcohol can increase aggression among users with untreated mental illness.

Finally, several researchers have documented a dose-response relationship between the number of traumatic events experienced and the development and severity of PTSD symptoms (Neuner et al., 2004; Maedl et al., 2010; Nandi et al., 2020;). A dose-response relationship

describes the magnitude of the response (PTSD symptoms) as a function of the exposure (traumatic events). Researchers once considered the dose to be the "severity" of the traumatic event, with events that were considered more traumatic yielding a greater probability of developing PTSD. However, researchers now focus on the dose as the number of traumatic events experienced (Neuner et al., 2004). Neuner et al. (2004) studied cumulative trauma exposure among refugees in the West Nile region. They found that after a certain threshold of traumatic experiences, the probability of developing PTSD reached 100%. Eighty percent of the participants who experienced 20-27 traumatic events in their lifetime met the PTSD diagnosis criteria, while 95% of the participants who experienced 20-27 events in the last year met the criteria (Neuner et al., 2004). One hundred percent of the participants who experienced 28 or more events in their lifetime or in the last year met the PTSD diagnosis (Neuner et al., 2004). This is consistent with Maedel et al. (2010), who found that when Somali refugees experienced two dozen or more traumatic events, the prevalence of PTSD was 100%. War, civil conflict, and state violence increase the likelihood that citizens will experience several traumatic events over the course of one year and for the entirety of the conflict, which could last decades.

2.2 Domestic Family Violence

DFV encompasses many forms of violence that occur between family members or people who are considered family, not only intimate partners. It includes violence between people who are cohabiting or not, but the violence occurs in a private sphere. While anyone can be a victim of DFV, it is most common that men perpetrate the violence against women and children in their family (Raising Children, 2019). Violence can be physical, verbal, emotional, psychological,

and/or sexual. Globally, DFV represents a considerable public health threat, particularly to women and children. The global lifetime prevalence of physical or sexual IPV for women that report ever having an intimate partner is 30% (WHO, 2013). The prevalence is highest in South-East Asia (37.7%), followed by Eastern Mediterranean countries (37%) and African countries (36.6%) (WHO, 2013).

Several long-term negative health outcomes are associated with DFV. Survivors of DFV are more likely to experience sexual reproductive health issues such as being more than 1.5 times as likely to have HIV/AIDs and more than twice as likely to have an induced abortion (WHO, 2013). Survivors are also more likely to give birth to a low weight baby (OR = 1.16) and to give birth prematurely (OR= 1.41) (WHO, 2013). Mental health disorders, such as depression and alcohol use disorders, are nearly twice as likely for survivors compared to the population (WHO, 2013). Finally, 42% of women affected by IPV experience physical injuries from their partner. Abuse from partners account for 13% of all homicides globally and 38% of female murders (WHO, 2013). In 2017, 87,000 women globally were murdered, 58,000 (67%) by an intimate partner or family member (United Nations Office on Drugs and Crime [UNODC], 2018). Victims of IPV are also nearly five times as likely to take their own lives (WHO, 2013).

Several international organizations have recognized gender-based violence (GBV) and IPV as human rights violations. In the United States, the Convention to End Discrimination Against Women (CEDAW)[2] instituted General Recommendation 19, proclaiming that states are not only obligated to refrain from committing acts of violence against women, but are also responsible for any private instances of violence against women if they fail to prevent and punish the acts

[2] The CEDAW committee includes experts on women's rights from around the world. The committee meets to discuss current issues of VAW across the world and establish recommendations, not mandates, for states to implement.

(Minnesota Advocates for Human Rights, 2003). General Recommendation 19 states that GBV is a "form of discrimination which seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men." The World Conference on Human Rights in Vienna in 1993 also called on states to take responsibility for acts of violence against women and the systems that protect or harm women (United Nations Office of the High Commissioner Human Rights, [OHCHR]).

Risk factors for experiencing and perpetrating DFV exist on the individual, interpersonal, community, and societal levels (Appendix A). Individual risk factors that contribute to DFV include being low income, abusing drugs or alcohol, experiencing depression, wanting power or control, being a victim of abuse, believing in strict gender roles, and having poor behavioral or impulse control (Centers for Disease Control and Prevention [CDC], 2019). Interpersonal risk factors include economic stress, social isolation, marital instability, and jealousy (CDC, 2019). Community factors are poverty, high alcohol consumption rates, and weak community sanctions (willingness to intervene or call authorities) (CDC, 2019). Finally, common societal risk factors are traditional gender norms, cultural norms that accept aggression, the existence and enforcement of state laws around DFV, and societal income inequality (CDC, 2019).

By understanding the root causes of DFV perpetration from the individual up to the societal level, it is clear that state conflict could cause or exacerbate these conditions. Countries that are recovering from conflict experience economic devastation and unemployment. The immediate focus of the international community and host country is on rebuilding physical infrastructure and the workforce, not on "private matters" occurring in the home. However, knowing what we do about the documented trend of the rise in DFV post-conflict, it is the responsibility of local and international organizations to respond to the ongoing threat of violence families face. While DFV

presents a threat to families across the world, post-conflict zones are especially susceptible to this kind of violence because of multi-level risk factors that are exacerbated by conflict.

2.2.1 Domestic Family Violence Post-Conflict

To date, the author could not find a study that analyzed rates of DFV post-conflict globally, but several studies have reported country specific trends. A study by Mattina (2017) published rates of domestic violence in African countries that experienced a civil conflict compared to those that did not (Appendix B). She found significant results showing that a greater percentage of women suffered from domestic violence in countries that experienced an armed conflict compared to those that did not. Taking a closer look at countries that have experienced conflict, a study conducted in Liberia by Kelly et al. (2018) found a 50% increase in risk of IPV in Liberian districts that experienced violence compared to districts that did not. The group also found a positive correlation between the years of conflict occurring in a district and the amount of IPV post-conflict. Specifically, women living in districts with four to five years of conflict were more than twice as likely to experience IPV compared to women living in districts without conflict (Kelly et al., 2018). Another study (Catani et al., 2008) compared DFV in Sri Lanka and Afghanistan and found a positive correlation between conflict related events and the likelihood of experiencing DFV. They also found that the father's alcohol use was a significant predictor of the number of domestic violence experiences by the child.

2.3 Conflict, Trauma, and Domestic Family Violence

The issue of VAW in conflict regions has only started to receive attention in the last 30 years, with more prominence in the previous decade. Still today, the majority of the work focuses on GBV that occurs during conflict and not on violence that persists after the conflict in the home. Until recently, the majority of the work in this area focused on providing legal, medical, and psychosocial services to survivors. Recently, organizations have worked on prevention by creating social campaigns to challenge the root causes of DFV, such as strict gender norms (Ward, 2013). While these kinds of campaigns play a crucial role in preventing DFV, they do not address the specific post-conflict factors that exacerbate DFV perpetration, in particular, the high rates of PTSD and depression resulting from combatant trauma and normalization of violence.

Research has shown that trauma resulting from conflict manifests differently than trauma resulting from other events. Catani et al. (2008) researched Sri Lanka as a case study because the country experienced decades of civil conflict (1983 – 2009) and a devastating tsunami (2005). The goal was to understand if DFV perpetration was related to experiencing traumatic events in general or if it was related more specifically to the experience of violent traumatic events. They reported that a father's exposure to conflict events in addition to their alcohol intake was a significant predictor of DFV perpetration in the home (Catani et al., 2008). The father's exposure to the tsunami, in contrast, was not a significant predictor of DFV perpetration. Therefore, the data suggest that violent experiences and substance abuse are important risk factors for DFV perpetration post-conflict.

There is also evidence that an individual's role in conflict results in different expressions of PTSD symptoms. Johnson and Thompson (2008) compared how combatants experienced violence to experiences of civilians. Combatants learned that looking for and responding to threats

is necessary to survive, making them more likely to experience hyperarousal PTSD symptoms such as hypervigilance (Johnson & Thompson, 2008). Hyperarousal is a heightened state of anxiety in which the individual is constantly looking and preparing for threats. Conversely, civilians learned that fear and submission were necessary to survive, making them more likely to experience the freezing and disassociating symptoms of PTSD. Therefore, the way the violence is experienced in conflict is also crucial to understanding how the trauma may manifest.

Section 2.2 of this paper discussed the root causes of DFV perpetration. Many of these root causes, such as poverty and substance abuse, are exacerbated in post-conflict environments. This creates multiple entry points for interventions. This paper will focus on two conflict social trends, cycle of violence and gender roles, to understand the recommended interventions.

2.3.1 Cycle of Violence Theory

The Cycle of Violence Theory contends that violent victimization, particularly physical abuse perpetrated by parents or caregivers, increases the likelihood of subsequent violent behavior by youth (Wright & Fagan, 2013). Recently, researchers have been exploring additional factors that contribute to the cycle of violence because not all children who experience abuse become perpetrators of abuse. Wright and Fagan (2013) expanded this theory by studying interpersonal violence in the context of neighborhood or community violence. The idea is the same; normalization of violence perpetuates violence as a coping skill or means of dealing with issues even in nonthreatening situations.

Repeated exposure to violence and traumatic events increases the probability of developing PTSD and adopting violent behavior. Research on cycles of violence focus on appetitive aggression and reactive aggression. Appetitive aggression describes perpetration of violence that

yields a positive or rewarding response. It is described as an “intrinsic enjoyment of violence” (Nandi et al., 2020, p. 392). Reactive aggression describes acts of violence committed in response to an actual or perceived threat (Nandi et al., 2020). Studies suggest that individuals in a hyperaroused state will be more likely to respond with reactive aggression because they are more likely to identify actual or perceived threats than individuals that do not experience hyperarousal (Nandi et al., 2020). The development of hyperarousal symptoms in ex-combatants is a sign of adaptation and a survival tactic. It is described in the following way: “Hyperarousal with its excessive alertness and responsiveness to sensory cues might, therefore, also be seen as a preparedness for fight or flight, enabling a rapid response to actual threat and increasing chances of survival in life-threatening situations” (Nandi et al., 2020, p.396).

A study of Burundi soldiers described a bi-cycle of violence between proactive-appetitive aggression and reactive-defensive aggression (Nandi et al., 2020). Appetitive aggression increases the likelihood of using aggression and experiencing positive feelings after using it. This creates a positive feedback loop for using appetitive aggression. Reactive aggression occurs in response to a threat or feelings of fear, anger, or anxiety (Nandi et al., 2020). An ex-combatant experiencing hyperarousal symptoms of PTSD would therefore be more likely to recognize actual or anticipate perceived threats because they are constantly on alert. Repeated exposure to traumatic events heightens PTSD symptoms and lowers the threshold for detecting threats (Nandi et al., 2020). A lower threshold for detecting threats makes reactive aggression more likely to occur. This results in a reward pathway for ex-combatants; reactive aggression becomes rewarding because it keeps them safe, causing the aggression to become enjoyable and thus appetitive (Appendix C). So, in conflict, violence is not only normalized, but it is essential for survival. Without therapy to address

the root causes of PTSD symptoms, ex-combatants may continue to act aggressively, even in the absence of threats, to feel safe.

2.3.2 Gender Roles Theory

As previously mentioned, strict gender roles are a root cause of DFV perpetration. In conflict and post-conflict regions, gender roles are in constant flux, exacerbating the likelihood of DFV. During conflict, women typically remain at home to take care of and provide for their families. They must take on both the traditional male and female roles for the household, creating fluidity in the gender roles and norms in the home. While many women experience traumatic events related to the conflict, many reported that they enjoyed having more responsibility and independence (Maedl et al., 2010).

Conversely, combatants, typically men, are in situations that strengthen traditional gender norms by encouraging hypermasculinity and violence. Some ex-combatants report violence being used against them as a means of control and personally experiencing torture, physical or sexual assaults. Others report being forced to watch or perpetrate such abuses. Either way, the message remains the same: violence equals control. Conflict creates a power imbalance, and it normalizes using violence as a way to assert dominance. An article by Bradley (2018) summarizes this phenomenon:

> This research indicates that the masculinities forged by armed conflict, in combination with the psychological wounds incurred by combatants, contribute to ex-combatants having an increased propensity to perpetrate DFV when they return home to their partners and children (p. 125).

The “masculinities forged by armed conflict” clash with the fluid gender roles established at home during the conflict. Women embrace new roles that do not conform to traditional gender norms and men perceive this as a threat to their masculinity. Furthermore, ex-combatants often have trouble finding or keeping jobs while they reintegrate into society. Poverty and unemployment are both root causes of DFV and they are escalated in post-conflict settings. Escalation results from not only the economic devastation of the conflict, but also from PTSD symptoms such as aggression, difficulty concentrating, flashbacks and self-medication with substances (Maedl et al., 2010). Therefore, violence is also used in the home to reinforce traditional gender roles and reestablish a hierarchy of power.

While traditional masculinities are created and encouraged during conflict, captors or commanders emasculate combatants to intimidate and establish power. Researchers are exploring how commonly commanders use rape as a weapon against male combatants to assert their control. Across the world, there is minimal research on sexual and gender-based violence (SGBV) perpetrated against men, especially during conflict. One study found that 65% of interviewed ex-combatants reported experiencing sexual violence during the war and 20% reported experiencing rape (Christian, et al., 2011). Male survivors also reported symptoms consistent with PTSD, amplifying PTSD symptoms caused by conflict. Survivors interviewed in a Democratic Republic of the Congo (DRC) study reported that they were no longer working outside the home because of “fear of encountering the rebels again, as well as social stigma and shame” (Christian et al., 2011, p.232). While female survivors of SGBV also face social stigma and shame, men experience it for different, gendered reasons.

Male survivors and service providers report that rape is used to humiliate and emasculate men by changing the community's view of them as a man to that as a woman. One service provider from the DRC explains male rape in the following way:

> They rape men to humiliate us, show power that they have captured everything and everybody, destroy men, masculinity and our culture, destroy families, show men that they are weak and don't have any power to protect themselves and their families (Christian et al., 2011, p. 235).

Additional emasculation tactics include captors forcing men to work in jobs that are considered "women's work" like taking care of children, doing laundry, cleaning, fetching water and so on. Male survivors who return home and perpetrate DFV do so to overcompensate for the abuse they experienced and establish their place at the top of the power hierarchy.

In conclusion, male ex-combatants receive many conflicting and confusing messages about gender roles and how they apply to them. On one hand, they are trained to fight and to be violent and aggressive, which are traditionally considered masculine traits. On the other hand, commanders challenge combatants' masculinity with sexual abuse and forcing them into traditionally female roles. When the conflict is over, ex-combatants overcompensate with hypermasculinity in response to fluid gender roles and to overcome the shame associated with the emasculation tactics that were committed against them.

2.4 Post-Conflict Stabilization

2.4.1 Disarmament, Demobilization and Reintegration Programs

Disarmament, demobilization, and reintegration (DDR) programs have become a crucial aspect of post-conflict stabilization and peace building. They are typically administered by international organizations such as the UN, World Bank, UNICEF, and others (Hanson, 2007). In recent years, there has been an effort to transfer the responsibility of DDR programs to national governments for sustainability. However, this is difficult for many reasons, from the fact that DDR programs have a short time frame to political instability post-conflict.

Disarmament refers to the "collection, documentation, control and disposal of small arms, ammunition, explosives and light and heavy weapons" from both combatants and civilians (Hanson, 2007). Additionally, ex-combatants turning in weapons are provided with information on benefits that they are entitled to and transportation to demobilization sites.

Demobilization refers to the "formal and controlled discharge" of combatants from armed forces or other armed groups (UN, 2020). This process officially disperses or reduces armed groups involved in the conflict and deactivates combatants who were involved. It also attempts to decrease the significance of emblems and norms associated with combat groups. The demobilization process includes the "reinsertion" stage in which combatants and their families are transported to temporary living conditions and provided with immediate needs such as medical assistance, food, water, shelter, and employment training. The reinsertion phase prepares ex-combatants for reintegration by providing cash payments and vocational training (Hanson, 2007). Since these are considered emergency services, they are typically provided short term (up to one year) to help families find stability and work towards independence (Maedl et al., 2010). The

director of the UN's DDR program says that too often, funding runs out before the program can advance to the reintegration phase: "Donors forget that these people need assistance to become productive members of the community—psychological counseling, trauma healing support, access to employment" (Hanson, 2007). Without psychological services to address the trauma, it is unlikely that most ex-combatants will successfully reintegrate into their communities.

Finally, full reintegration occurs when ex-combatants acquire civilian status and attain sustainable employment and income. This is a development goal for the country, not just non-governmental organizations (NGOs), and requires active assistance at the national and community levels. Unfortunately, combatants receive the preliminary benefits of reinsertion but are not as likely to achieve sustainable financial stability or job security (Ball & van de Goor, 2006). This could be for a variety of reasons from few job opportunities in post-conflict environments to community stigma against ex-combatants.

2.4.2 Challenges to Reintegration

Disarmament and demobilization are the most successful aspects of DDR programs for a couple of reasons. First, they are time-bound and quantifiable projects (Ball & van de Goor, 2006). Since DDR programs were developed as an emergency response, they are intended to be short term. However, reintegration is a long process that depends on political stability, economic opportunity, community healing, and other complicated issues that cannot be rushed and are outside of the donors' control. Second, disarmament and demobilization programs are a part of peace-keeping mandates and because of this receive funding from peace-keeping organizations (Ball & van de Goor, 2006). Long term funding for reintegration projects is not guaranteed. However, communities, especially individuals who fit into a vulnerable group, require long term,

substantial assistance (Maedl et al., 2010). DDR programs consider former child combatants or abductees, female ex-combatants, and ex-combatants with physical or mental disabilities as vulnerable groups (Maedl et al., 2010). When DDR programs cannot provide adequate therapy to persons with physical or psychological disabilities, they offer additional financial relief instead, which can lead to dependence on the state (Maedl et al., 2010).

There are several recommendations to make DDR programs more successful. One is to involve ex-combatants in the program development or implementation. Involving ex-combatants help to tailor programs to specific needs that may not be apparent to those who have not shared the same experiences. It also helps ex-combatants begin to identify as a civilian in their communities rather than a combatant in armed groups (Ball & van de Goor, 2006). Additionally, monitoring and evaluation needs to take place for DDR programs. These can be used to identify strengths and weaknesses of the programs and to advocate for additional funding and longer term rehabilitation programs.

3.0 Case Studies

This chapter discusses the issues of PTSD and DFV post-conflict with two case studies. The first is Liberia and the second is Peru. This chapter also discusses the policies and programs that were implemented in these countries to address issues of mental health and DFV post-conflict.

3.1 Liberia

Liberia, located along Africa's west coast, is Africa's oldest republic and the only African country that has never been subjected to colonial rule (Britannica, 2020). In 1821, the land was established for free United States (U.S.) slaves, referred to as the Americo-Liberian ethnic group (Britannica, 2020). The two other main ethnic groups in Liberia are the indigenous peoples who migrated from western Sudan in the fifteenth century and immigrants from surrounding west African countries. Within these broad groups, there is a great deal of ethnic and cultural diversity. The most populous religious denomination in Liberia is Christianity (85%) followed by Muslim (12%) with the remaining individuals identifying as nonreligious or traditional beliefs (Britannica, 2020). Liberia was engaged in two internal conflicts, the first occurring from 1989-1997 and the second from 1999-2003. Until 1979, the Americo-Liberians peacefully ruled Liberia by its one-party system (M'Cormack, 2018). At this time, President Tolbert raised the price of rice, a household staple. In a coup, President Tolbert and his staff were killed and replaced by Samuel Doe, a member of the Krahn ethnic group. Doe suspended the constitution and created an authoritarian regime that targeted other ethnic groups. In 1989, Charles Taylor, a former Doe ally,

led a rebellion group to overthrow Doe. He easily gained the support from individuals of other ethnic groups that had been targeted by Doe's regime. Doe was tortured to death and civil conflict ensued among rebel groups. Peace-keeping groups were sent in from surrounding countries, but Taylor's military reacted with violence. In 1997, Taylor was elected as president with promises of ending the war if citizens voted for him.

For two years, disarmament programs attempted to bring peace and stability to post-conflict Liberia. However, with Taylor enabling ethnic tension and doing little to resolve poverty, the efforts failed and led to a second civil conflict (Peace Building Data). The conflict ended in 2003 when two rebel armies forced Taylor to surrender in the midst of peace talks.

The Liberian Truth and Reconciliation Commission (TRC) estimated that the 14 years of conflict killed more than 250,000 people and left over one million displaced (Peace Building Data). The Liberian conflicts and the widespread use of child soldiers gained international attention. Taylor's army forced children to commit horrendous acts against family members so they would be shunned by their community. When the conflict ended in 2003, the TRC estimated that 21,000 child soldiers would need to be reintegrated into society (Peace Building Data). In addition to the human life toll, Liberia's economy was devastated during and for years following the conflict.

3.1.1 Post-Conflict Mental Health

As discussed in Chapter 2, long term conflict has serious consequences for the mental health of survivors. To date, there are no national data on how the 14 years of conflict affected the mental health of citizens and ex-combatants specifically. However, several research groups have conducted independent studies to understand the effect of combatant status on mental health in Liberia.

A study by Johnson et al. (2008) analyzed the association between combatant status, exposure to sexual violence, and rates of PTSD and major depression in post-conflict Liberia. The study used random sampling in each of Liberia's 88 districts. A total of 1,666 individuals, one-third of whom were ex-combatants, completed interviews. One third of the ex-combatants were female. The research team found differences in the experiences of female versus male ex-combatants. Male combatants were more likely to be involved in physical combat, act as spies or guards, or to train or be trained as a soldier. Female combatants were more likely to be held in sexual servitude (Johnson et al., 2008). Male combatants were also more likely to abuse drugs during the conflict and to continue abuse of drugs post-conflict than female combatants and civilian males (Johnson et al., 2008). Finally, compared to civilian men, ex-combatants were significantly *($p<0.001$)* more likely to have experienced sexual violence (33% of ex-combatants compared to 9% of civilian men) (Johnson et al., 2008).

The team estimated the prevalence of PTSD for the adult Liberian population to be 44% (Johnson et al., 2008). The study found that the experience of sexual violence during the conflict had a strong effect on the development of PTSD. Forty-six percent of male ex-combatants who did not experience sexual violence met the criteria for a PTSD diagnosis compared to 81% of male ex-combatants who did experience sexual violence (Johnson et al., 2008). Rates of PTSD were slightly lower for female compared to male ex-combatants. Based on these data, the researchers are beginning to understand the severe trauma associated with combatant status and how it is compounded by the experience of wartime sexual violence.

Similar trends were observed for measures of major depression disorder (MDD). Fifty-two percent of male ex-combatants met the criteria for MDD, rising to 64% among those who experienced sexual violence (Johnson, et al., 2008). A striking 25% of male ex-combatants who

experienced sexual violence reported suicidal ideation. Male ex-combatants were more likely to abuse drugs and alcohol (14%) than civilian men (3%) (Johnson et al., 2008). Regardless of combatant status, participants reported that their access to health care and mental health services was poor. They cited two main reasons for not having access to services they need: not having the ability to pay and not having access to a facility in close proximity (Johnson et al., 2008). Higher rates of untreated PTSD and MDD in former combatants compared to civilians and limited access to mental health services likely contribute to high rates of substance abuse.

The Johnson et al. (2008) study allows comparisons of the independent and combined effects of combatant status and sexual violence. There is a great stigma and shame for male survivors of sexual violence in Liberia, discouraging many from talking about what happened to them. Even NGOs and other organizations that participate in post-conflict rehabilitation predominately focus on sexual violence that is used as an act of war against women. This unintentionally adds to the stigma and shame that male survivors feel. Perhaps it is not surprising that male survivors are more likely to rely on drugs and alcohol to cope with their trauma. The Johnson et al. (2008) study provides a strong argument for why post-conflict mental health services are so crucial.

3.1.2 Domestic Family Violence

Liberia is ranked 176 out of 189 countries on the Gender Inequality Index (GII), a measure of gender inequality in the human development, empowerment, and economic status sectors (United Nations Development Programme [UNDP]). While the GII does not directly measure attitudes about VAW, it does provide insight about factors that enable it. For example, the empowerment sector measures the number of women who are in decision making, political

positions which has a direct effect on polices regarding VAW. Additionally, it is widely accepted that high rates of gender inequality are associated with high rates of VAW (WHO, 2009).

As predicted based on the GII, Liberian women experience high rates of various forms of violence. According to the UN Women Global Database on Violence Against Women estimates that 38.5% of women experienced lifetime physical or sexual IPV and 35% experienced this violence in the last year (UN Women, 2016). It is important to note that while instances of IPV are notoriously underreported, regions with greater gender inequality are likely to be more affected by underreporting. In Liberia, cases usually go unreported for three main reasons. First, patriarchal social norms view IPV as something that the victim deserved. Second, until recently, domestic violence was not illegal. Finally, there is limited infrastructure for victim services where survivors can go for help.

In post-conflict Liberia, women's movements advocated to make forms of VAW illegal. However, it was not until 2019 that Liberian President George Manneh Weah along with the Ministry of Gender, Children and Social Protection signed the Domestic Violence Act to abolish all forms of violence against women, children and men (Front Page Africa [FPA], 2019). However, because Liberia has formal and informal systems of law, it is likely that many women will still not be protected from DFV. While many African countries have hybrid systems of law, formal versus traditional, Liberia is unique because of the Americo-Liberian colonization history (M'Cormack, 2018). Its three-fold system consists of a formal justice system (modeled after the United States), a customary system for personal and family issues, and a "traditional" system common with Indigenous Liberians (M'Cormack, 2018). "Traditional" systems are found in rural areas of Liberia and are headed by respected men and women or religious leaders of the village. In these

areas, formal authorities rarely become involved with instances of DFV and women rarely have access to the resources they need to leave the abusive situation.

3.1.3 Combatant Trauma and Perpetration of DFV

As discussed in chapter 2, there is a positive correlation between ex-combatant exposure to traumatic events and the perpetration of DFV. Liberia's 14 years of conflict has created a situation that makes it a good case study in regard to this issue.

A study by Vinck and Pham (2012) was conducted ten years after the Liberian conflict ended to understand the link between exposure to traumatic events and perpetration of DFV. The data showed that the likelihood of a man beating his partner varied based upon different traumatic experiences. A man's exposure to conflict violence increased the likelihood of him beating his spouse and that the likelihood of beating their spouse were highest for men who were involved in combat (Vinck & Pham 2012). The odds ratio (OR) for beating a spouse was the highest for men who "took part in the conflict" (OR = 1.79, $p < 0.01$).. The OR was also high for men who were exposed to crimes (OR = 1.23) and experienced direct war violence (OR = 1.12, $p<$). The team also studied correlations between symptoms of PTSD and depression with exposure to traumatic events. The strongest correlations with PTSD symptoms were witnessing war violence and participating in the conflict (Vinck & Pham, 2012).

Kelly et al. (2018) researched how the severity of conflict violence, measured by fatalities, affected the amount of IPV perpetration in post-conflict Liberia. The team found two important distinctions. First, women living in districts that experienced fatalities were more than 1.5 times more likely to report experiencing IPV (Kelly et al., 2018). This was true when controlling for all potential confounding variables. Second, the length of a conflict also impacted the likelihood of

self-reported IPV. For example, women living in districts that experienced three or more years of conflict were significantly more likely to experience IPV than women living in districts with fewer than three years of violence (Kelly et al., 2018).

3.1.4 Programs and Policies Implemented

Following the end of the conflict in 2003, Liberia formed a transitional government and established national elections to be held in 2005, when Liberia elected its first female president, Ellen Johnson Sirleaf. With an 85% unemployment rate and with 76% of the population living on an income of less than one dollar per day, President Sirleaf had an extensive agenda to rebuild the capacity of the country. This section will focus on policies related to GBV and on work of international peace building organizations in post-conflict Liberia.

From 2003 to 2004, Liberia implemented a disarmament, demobilization, rehabilitation, and reintegration (DDRR) program to reintroduce ex-combatants into society. The first phase of the program included disarmament and demobilization, the process of removing weapons from ex-combatants and also separating ex-combatants from their "command structures" (Jaye, 2009, p.12). The second phase, rehabilitation and reintegration, was established to help ex-combatants re-enter society by focusing on three domains: formal education, vocational training, and social reintegration (Jaye, 2009). The disarmament portion occurred from April 2004 through March 2005 when 101,495 ex-combatants were disarmed and demobilized (Jaye, 2009). This was more than twice the number of ex-combatants that was expected, which forced the peace building team to expand its efforts.

After disarmament, former combatants were transferred to demobilization sites. Here, they received medical attention, attended weekly meetings on human rights issues, and received half of

their stipend ($300USD) to prepare them for the second phases of rehabilitation and reintegration. Over 11,000 child soldiers went through the disarmament and demobilization process (Jaye, 2009). Women and girls were separated from men and boys during the demobilization process. Many feared that participating in the process would be re-traumatizing because they would be in close proximity to male ex-combatants who were violent towards them or their families (Jaye, 2009).

In the second phase, ex-combatants moved back to their communities and participated in either education or vocational training. At this point, they also had the option to use psychosocial services. However, looking retrospectively at the process, many experts believe that these services should have been offered earlier, in the demobilization phase.

> One aspect of the rehabilitation program that has been ignored is psychosocial counseling for ex-fighters. Ex-fighters should have undergone psychosocial evaluations at the D2 (demobilization) site, where predischarge orientation was carried out, but this did not happen. Consequently, even though there was evidence that ex-fighters, including child soldiers, were forced to use marijuana and other drugs during the war years, very little was done to address this as part of the rehabilitation process. (Jaye, 2009, p.17).

According to Abramowitz (2009), NGOs, donors, and bilateral and multilateral organizations were against directing DDRR funds to addressing mental health and psychosocial services of ex-combatants. A "loss of confidence in the cultural propriety of mental health initiatives" (Abramowitz, 2009, p.14) caused DDRR funds to be directed towards educational and vocational training for ex-combatants in addition to direct monetary aid for those who were suffering too much physically or mentally to participate in the trainings. From 2005 to 2008, only one psychiatric hospital existed to serve 40 patients and one NGO provided mental health care across the entire country. Neither one of these services prioritized serving ex-combatants

(Abramowitz, 2009). With thousands of former combatants living with untreated PTSD, the community reports constantly seeing veterans struggling with alcohol abuse and psychosis (Abramowitz, 2009). Locals refer to this as "ex-combatant trauma." The psychological suffering of ex-combatants on the streets contributes to the stigma against them. Some believe that they are being punished for sins they committed during the conflict.

Overall, the DDRR program in Liberia is considered a success by the international community. Surveys conducted in 2006 show that ex-combatants who completed the rehabilitation and reintegration (RR) portions of the program felt accepted by their communities at higher rates than ex-combatants that did not complete the RR portions (5% compared to 55%) (Jaye, 2009). The UN, USAID, and UNMIL implemented another survey in 2007, which yielded unsatisfactory results. The majority of Liberians stated that they did not feel that the DDRR program was successful in helping ex-combatants reintegrate into the community. They stated that many ex-combatants were still unemployed or could find work only in dangerous sectors such as diamond and gold mining (Jaye, 2009).

There are also concerns with how well Liberia's DDRR program met the specific needs of female ex-combatants. The experience of female combatants in Liberia were complex. While some took on household roles, such as cooking and cleaning, other were engaged in physical combat. There was also a significant group of women that served as commanders. All of these various roles effect the day-to-day experiences they had during the conflict and effect the needs they will have post-conflict. Female ex-combatants experience additional barriers to community reintegration because of their gender. Women and girls are especially stigmatized by when they return to their communities for their involvement in the conflict or for having children during the conflict. It is also more difficult for women and girls to find economic opportunities post-conflict. This is in part

because girls in Liberia do not have equal access to education that boys have. For these reasons, many female ex-combatants stay with commanders or boyfriends that they during the conflict. Many that developed a dependence on their commanders during the conflict continue this post-conflict (Specht) . Unfortunately, the DDRR program in Liberia, like many others, did not involve female commanders in the peace talks or reintegration processes meaning female ex-combatants were at an even greater disadvantage than male ex-combatants.

Liberia also formed the TRC in 2006 to investigate human rights violations that occurred during the conflict and to give victims and combatants the opportunity to talk about their experiences. The TRC has inspired civil society working groups to address issues of transitional justice in their communities to work on peace and integration of Liberians from different areas. This kind of transitional justice is important in post-conflict environments in which combatants perpetrated horrendous acts of violence against their neighbors, families, and friends. Many combatants were also victims of crimes or forced into combatant status, which complicates the idea of what should be considered justice.

3.2 Peru

Peru is a country along the southwest coast of South America, bordered by Colombia, Ecuador, Chile, and Brazil. While Peru is a tropical country located on the equator, the range in elevation across the country causes diversity in climate. The country is typically described by three longitudinal regions: the Sierra coastal desert to the west, the tropical Amazon rainforest to the east, and the Andes mountains in the center (Davies, 2020). Peru is ethnically diverse, with

Quechua Indians, or Indigenous Peruvians, comprising nearly half of the Peruvian population. The second most populous ethnic group is mestizos, consisting of persons of mixed Indian and European descent. Third most populous are persons of European descent (Davies, 2020). With the arrival of the Spanish conquerors, a persisting caste system formed in which Europeans continue to hold the majority of political power in the country. Mestizos make up a middle-class society in Peru and the Indigenous Peruvians are most likely to live in poverty (Davies, 2020).

Peru was the last country in Latin America to win Independence from Spain in 1824. Following its independence, Peru struggled to reach political stability, alternating between periods of rule by democratic regimes, civilian regimes, and military groups. The country had widespread inequality between individuals of Spanish descent and Indigenous populations. Indigenous Peruvians were the victims of systemic policies that marginalized them economically and politically (The Center for Justice and Accountability [CJA]).

In the 1960s, radical Leftist movements developed across Latin America as a result of widespread racial and ethnic inequality. In Peru, the two largest Leftist groups were Shining Path and the Tupac Amaru Revolutionary Movement (MRTA) (CJA). Shining Path, a guerilla army led by Abimael Guzman, consisted of 10,000 combatants, and desired a classless and moneyless society (Gurmendi, 2019)[3]. Attacks started in rural regions, particularly in the Andes, where Shining Path killed local government leaders and replaced them with their own members, creating a military state for years in Indigenous communities. Communities in the Andes were vulnerable

[3] While the dates of the Peruvian conflict are commonly accepted as 1980 – 2000, scholars stress that these are arbitrary dates. Gurmendi (2019) asserts that the Shining Path was active before 1980, disrupting election processes. He also states that the Shining Path was essentially inactive by 1997, and that the conflict was arbitrarily declared over in 2000 because of the collapse of the Fujimori government.

because of their location far from the city and desirable because of their food growing capacity, which Shining Path wanted to control (Gurmendi, 2019).

Throughout the 1980s, the Peruvian government downplayed the threat of Shining Path. This is not surprising because the people most affected were poor, Indigenous Peruvians in the Andes (Laplante & Holguin, 2006). However, when the Shining Path movement became more pervasive in the city and committed deadly terror attacks, the government could no longer ignore the group. In 1990, President Alberto Fujimori was elected for his first term running on an anti-corruption campaign. Frustrated with limitations to his power to fight the terrorism, Fujimori suspended the Constitution in 1992 (Laplante & Holguin, 2006). In the following years, state authorities also committed human rights violations against innocent civilians in addition to rebel groups. Sexual violence, torture, arbitrary imprisonment, and brutal killings were rampant throughout the country (Laplante & Holguin, 2006).

In 2000, the Peruvian congress declared President Alberto Fujimori morally unfit to lead and he was forced to flee the country, allowing a new democratic government transition in Peru. In 2001, the Truth and Reconciliation Commission investigated the human rights violations that took place during the 20-year conflict. The efforts found that military groups on all sides were responsible for 69,000 deaths or disappearances, most of whom were civilians (CJA) and displacement of 600,000 Peruvians (White, 2009).

3.2.1 Post-Conflict Mental Health

To date, the author has not found any articles that collected quantitative data on mental health outcomes for ex-combatants in the Peruvian conflict, either from rebel groups or state authorities. A few studies reported qualitative data on ex-combatants experiencing PTSD

symptoms and high rates of substance abuse among ex-combatants. For example, Otsby et al. (2019) found that after the conflict, ex-combatants began feeling guilt or shame as they realized the violence they committed was not justifiable. With little access to mental and behavioral health professionals, many ex-combatants relied on marijuana, cocaine, and alcohol to cope with their emotions.

The majority of the research on post-conflict mental health in Peru has focused on mental health of survivors, especially women and children. A case study conducted in 2009 in the rural highlands of Peru found that 25% of adults reported symptoms of trauma (Leatherman & Thomas, 2009). A 2012 epidemiological study (Toyama et al., 2017) conducted across Peru found that one in five Peruvians suffered from mental illness. The study also reported that rates of mental illness differed based on socio-economic status and violence experienced during the conflict. The Ayacucho region was found to have a lifetime prevalence of 50.6% for mental illness (Toyama et al., 2017). While the data do not tell us about the prevalence of mental illness in ex-combatants specifically, it does show the national burden to be higher than the average global burden of 1-9% and that the burden is higher in areas most affected by the violence of the 20-year conflict. While the Peruvian government has tried to incorporate mental health services into healthcare, many Peruvians still do not have access and do not receive proper care for mental illnesses (Toyama et al., 2017).

3.2.2 Domestic Family Violence

The Gender Social Norms Index (GSNI) measures the percentage of a population that holds biases against women in the following areas: politics, economy, education, and physical integrity (UNDP). Globally, the report showed that nearly 90% of men and women hold a bias against

women in at least one of these areas. In Peru, the percentage of people with bias against women in politics, economy, and education area all relatively low (38%, 27%, 14% respectively) (UNDP). In contrast, the percentage of people with a bias against a woman's physical integrity, an indicator that serves as a proxy for detecting attitude towards IPV and reproductive rights, is 80%. This indicates a social or cultural acceptance for VAW from both men and women.

From 2000-2003, WHO conducted a multi-country study on DFV. In Peru, the study collected data on the capital, Lima, and a city in the Andes, Cusco. In Lima, the prevalence of physical or sexual violence by a partner was 51% for ever-partnered women, which is higher than the global prevalence of 30% (WHO, 2005). In Cusco, the prevalence of physical or sexual violence by a partner was 69% (WHO, 2005). The study found that only one third of the women who experienced IPV sought professional help from either the police or health care providers (WHO, 2005). When women were asked why they did not report the violence or seek help, over 25% said the violence was "normal or not serious" (WHO, 2005, p.2). Another common reason for not reporting in Lima (15%) and Cusco (28%) was because they felt shame or thought that they would not be believed (WHO, 2005).

Peru has implemented several laws and policies in attempt to counter the pervasive issue of VAW. In 1993, Peru passed the Family Violence Law to secure the process of handling cases of DFV by strengthening roles and responsibilities of authorities involved in handling the cases (Human Rights Watch [HRW], 2000). The law has since undergone several amendments to address a few critical flaws. Up until 2008, for example, women were required to attend conciliatory meetings with police and the abuser before prosecution could begin (Ferriera, 2009). HRW found that conciliatory meetings usually focused on the woman's behavior as a cause of the violence against her. For example, a woman may be blamed for the abuse if the husband claims

that she disobeyed him (HRW, 2000). The meetings resulted in women agreeing to modify their behavior to prevent additional abuse from their partners rather than addressing the perpetrator's actions, and cases rarely made it to official prosecution. The 2008 amendment also reinforced that police are responsible for handling cases of DFV because historically police did not take these cases seriously (Ferriera, 2009). However, even with strong laws against DFV, the data show that Peruvian women still experience DFV at rates above the global average.

The social, racial, and economic inequality that contributed to the 20-year Peruvian conflict also contributes to how citizens and authorities perceive DFV. Just as communities in the Andes were the main targets during the conflict, women in these communities continue to experience higher rates of violence. Feminist scholars emphasize the importance of intersectionality in the case of Peru, that violence against certain groups of women is more normalized because of sexist and racist ideologies held by authorities and citizens (Boesten, 2014).

> Looking closely at the workings of gender in one society shows that gender norms differ according to cultural and ethnic groupings. This does not (only) mean that gender practices may be different among, for example, the Amazonian indigenous as compared to coastal mestizos, but that society ascribes naturalized interpretations of sexed bodies to gendered (and racialized) bodies. In other words, society may attribute differentiated sexual behaviors and possibilities to certain populations based on assumptions of gender and race. (Boesten, 2014, p.221).

A Peruvian man describes how inequalities pre-conflict encouraged violence against Indigenous women and encouraged Indigenous men to participate in the violence.

> Soldiers who are abused because of their race or class and who are taught to associate masculinity and violence, Indianness and brutality, poverty and victimization, learn how

> to abuse others on the same grounds. They will learn to exert sexist violence over women, racist violence against indigenous groups, and class violence against the poor (Boesten & Fisher, 2012, p.3).

The normalization of violence based on gender and class during the conflict encouraged the same trends to continue post-conflict, as evidenced by quantitative data from WHO's study and from interviews of Indigenous Peruvians.

3.2.3 Combatant Trauma and Perpetration of DFV

To date, no quantitative studies on the rise of DFV in post-conflict Peru were found. However, researchers and Peruvian mental health care workers have collected qualitative data, usually through interviews, that describe the trend and offer explanations for why it occurs.

Even though DFV was pervasive before the 20-year Peruvian conflict, increased acts of VAW that occurred during the conflict persisted post-conflict. Combatants were encouraged to commit human rights violations, especially sexual violence to systematically reinforce existing ethnic and caste inequalities in Peruvian society. Unlike Liberia, where many women were actively involved in combat, Peruvian female militants were often forced into domestic positions. Anthropologist Kimberly Theidon notes a strong division in "space and activities" by sex (Boutron, 2015, p.8). While Andean men were recruited to defend their communities and serve for the militant group, women were recruited to serve the militants. Women were expected to cook, clean, and have regular sexual relations with male militants. According to Boutron (2015), this established a practice of patriarchal gender roles that would persist in the home after the conflict. The normalization of the acts of violence during the conflict led to the development of appetitive aggression, causing them to continue post-conflict (Boesten, 2011). Many survivors of abuse

testify that the conflict "created new forms of gender-based violence" that now commonly occur in the home (Boutron, 2015, p.8). Boutron (2015) believes that the gender roles established from political violence during the conflict were replaced by post-traumatic syndrome after the conflict, leading to the perpetuation of violence in the home and the new forms of GBV.

Three main factors at the individual level help explain the rise of DFV in post-conflict Peru. First, ex-combatants return to communities before shedding their "exaggerated masculinities" forged by the conflict (Boesten, 2011, p.125). This includes desensitization to violence and the normalization of using it as an accepted way to solve problems. In many cases, women who were captured by military forces report being beaten upon returning home because their husbands accused them of infidelity, saying that the women must have done something to encourage their capture and subsequent sexual abuse (Boesten, 2011).

Second, ex-combatants commonly use alcohol, cocaine, and marijuana to cope with untreated trauma. One case study from Peru describes an increase in interpersonal and domestic violence and substance abuse as a rampant issue in rural regions (Leatherman & Thomas, 2009). A psychologist describes a session with her patient whose husband was suffering from untreated trauma and abusing substances to self-medicate. She says that "He became like a monster," (Otsby, 2019, p.2.) and describes that he would dissociate and become physically abusive to her. These events are not uncommon in post-conflict environments and the likelihood of them occurring has been shown to have a positive correlation with the amount of time the combatant was involved in conflict (Otsby, 2019).

Finally, men fear a changing social structure that shifts towards gender equality and leaves them behind. Therefore, violence is used to reassert their dominance and a woman's subordination to them. The economic devastation that is caused by conflict is also a reason for men to feel stress,

because in patriarchal societies men are groomed to be the provider of financial support. Therefore, Peruvian men are anxious that they cannot provide financially, or they feel threatened by their female partner's ability to provide more than they can, resulting in men perpetrating violence to overcompensate (Otsby et al., 2019).

On the societal level, a contributor to post-conflict DFV is impunity for perpetrators of wartime sexual violence. One reason for impunity is that the narrow definition of sexual violence excludes many instances from being legally considered sexual violence (Boesten & Fisher, 2012). Also, crimes of sexual violence have historically been considered "common crimes" rather than human rights violations, causing prosecutors to turn down cases (Boesten & Fisher, 2012). When VAW goes unpunished, it not only discourages women from reporting, but also teaches men that there are no consequences for such crimes.

3.2.4 Programs and Policies Implemented

The Truth and Reconciliation Commission (TRC) worked from 2001-2003 to publish reports on the violence from 1980-2000 and to make recommendations going forward. The first recommendation was justice for survivors of the wide range of human rights violations. The council forwarded 43 cases of perpetrators from opposition groups and state militia. The second step was to begin a search for the thousands of Peruvians who were reported missing. Third, anyone who suffered abuses, loss of life, or loss of assets from the conflict was offered support and reparations. Reparations in the health field were provided to victims for mental and physical health needs, with special focus on mental health services to women. The final recommendation was for institutional reform, focused on solidifying the strength of the State to prevent another such conflict (Friedman, 2016). The TRC interviewed militants to give them the opportunity to

speak about their involvement in the conflict and to speak about any human rights violations they experienced. They found that female militants experienced a wide range of abuses, including torture, rape, sexual humiliation, and psychological manipulation even after being sentenced to prison by the guards (Boutron, 2015).

Peacebuilding efforts have predominately focused on finding and serving the hundreds of thousands of internally displaced persons (IDPs). However, flaws in implementation have caused the programs to be considered unsuccessful. The major flaw is the process in which IDPs apply for the benefits that they are entitled to receive. The government insists that IDPs provide proof that they were displaced, such as documentation of their previous residence (White, 2009). Because IDPs are usually forced to flee their homes quickly, many do not have these documents and cannot apply for the specific reparation programs that serve special needs of IDPs.

The author did not find any literature on implementation of DDR programs for ex-combatants. One reason for this is that the government and Shining Path militant forces continue to defend their role in committing human rights abuses. The government states that they were responding to terror attacks committed by Shining Path, while the Shining Path defends their actions saying it was not terrorism but "the people's war" (Rios, 2019, p.48). Therefore, with both groups blaming acts of violence on each other rather than acknowledging their wrongs, ex-combatants and militants cannot completely reintegrate into society and victims do not receive justice.

While the importance of mental health services was stressed in the Truth and Reconciliation Committee, the services were directed towards Indigenous communities that suffered the most violence and loss at the hands of Shining Path. The author argues that Peruvian society and ex-combatants would benefit from addressing mental health needs of ex-combatants

in two ways. First, many combatants were forced, threatened, or tricked into joining militant groups. Many were members of marginalized groups and did not have another choice or truly believed they were fighting for their rights. However, many realized post-conflict that violence they committed was not justified. Second, ex-combatants who are not reintegrated or accepted back into their communities are more likely to rejoin armed groups where they will feel accepted, leading to future instability and violence.

4.0 Policy and Program Recommendations

This chapter presents evidence-based interventions for violence occurring in the private sector post-conflict environments. The recommendations will focus on treating PTSD, depression, and substance abuse in ex-combatants. The goal of these interventions is to decrease the rates of DFV that rise in post-conflict environments.

4.1 Narrative Exposure Therapy

In post-conflict regions, rates of PTSD are more severe than the global burden but resources are rarely allocated to the treating it. Narrative Exposure Therapy (NET) is a widely accepted therapy to treat PTSD, particularly for people with multiple exposures to traumatic events, making it ideal for individuals that have suffered from political violence (American Psychological Association [APA], 2017). It can be completed individually with a therapist or in small groups. NET works at the neurological level to change the way traumatic memories are stored in the brain. The hippocampus is the region of the brain that is responsible for storing memories. In instances of extreme stress, the hippocampus is compromised while the brain region responsible for processing fear, the amygdala, is overstimulated. Overactivation of the amygdala reinforces the fear associated with the traumatic event in the survivor's brain so that when the traumatic memory is triggered, so is the intense fear response. How NET works on these processes is best explained by Robjant and Fazel (2010):

> This disproportionate engagement of the neural structures (amygdala and hippocampus) means that memories for traumatic events differ from normal memories in that they include an increased number of cues, and the associations between cues are stronger. As a consequence of these differences, traumatic memories can be more easily activated. At the same time, reduced functioning of the hippocampus means that spatio-temporal information is not incorporated into the memory, making it very difficult for the individual to narrate the event. Furthermore, the lack of contextual information means that the individual maintains a sense of current threat when the memory is activated and the autobiographical memory is disrupted. (Robjant & Fazel, 2010, p.1032).

Overactivation of the amygdala interferes with the hippocampus's ability to process the traumatic event in its entirety. What is stored is the psychological and physiological stress associated with experiencing the event. When an individual experiences multiple traumatic events, the fear networks and responses strengthen, causing severe disturbance in everyday life (Robjant & Fazel, 2010).

In the first step of NET, therapists work with survivors to create a list of all traumatic events in the patient's lifetime in addition to a few significant positive events. The survivor narrates the events in chronological order, allowing them to relive the events in the safety of the therapist's presence. The survivor expresses psychological and physiological sensations they experienced during the traumatic event, for example, smells associated with the event or what they saw or heard. This allows patients to reprocess the event in a safe environment in contrast to the triggered state. This recodes the memory in their brain so that it induces less of a stress response, decreasing symptoms of PTSD (APA, 2017).

NET has been adapted to work with children as well, as KidNET. In these sessions, therapists use visual aids. For example, a therapist gives the child a long rope to symbolize their lifetime. The child places stones across the rope to symbolize traumatic events in their lives and flowers to symbolize happy events. To help the child narrate their story, a therapist sometimes uses drawings or other artistic expressions. Both NET and KidNET have been proven to be successful when implemented in populations that have had multiple traumatic exposures (Youth.gov). Additionally, research has shown that NET applies across many cultures to describe psychological suffering and success in training local, nonmedical persons in administering NET sessions.

4.1.1 Narrative Exposure Therapy in Post-Conflict Environments

NET has been administered in pilot studies across low to high income post-conflict regions. Hermenau et al. (2013) administered NET for ex-combatants in Rwanda, Uganda, and the Democratic Republic of the Congo (DRC). Their program, NET for Forensic Offender Rehabilitation (FORNET), was adapted to include treatment for symptoms of PTSD and appetitive aggression to help ex-combatants transition from identifying as a combatant to a civilian (Hermenau et al., 2013). Like NET, FORNET asks ex-combatants to recall happy and traumatic events in their lives. In addition, FORNET asks participants to recall violent acts that they experienced or perpetrated. This group used rope to signify their lifespan, stones to identify traumatic events, flowers to identify happy events and sticks to identify violent acts. The stick is meant to keep the violent events neutral (Appendix D).

Before continuing with the traditional NET session where participants narrate the events in chronological order, the therapist asks the participant questions about the violent events. First, the therapist asks about the initial violent act they were a part of and about emotions associated

with it. For example, ex-combatants are asked about which incident made them feel most powerful or most afraid (Hermenau et al., 2013). They can work with the therapist to combine the visuals, for example, combining a stone with a stick, to represent complex emotions. When the participant and therapist feel the visual aids are complete, the remaining sessions are dedicated to discussing the most important events on the timeline. When discussing the most violent acts the ex-combatant was involved in, the therapist asks about their feelings and emotions in the moment of that act and how it makes them feel currently. When the sessions are nearing an end, the therapist asks for details on the last time the ex-combatant left a military group and focus on the negative experiences they had as a combatant.

The Hermenau et al. (2013) study held four one on one sessions with just the therapist and participant and then held group sessions. The group sessions provided ex-combatants an opportunity to speak in the safety of others who have shared experiences. The therapist encourages participants to talk about what they want to achieve when transitioning from combatant to civilian status. Finally, therapists encourage participants to work together to develop goals and ways to achieve them. It is crucial for ex-combatants to have people that they feel safe sharing vulnerabilities with while they are reintegrating into their communities.

The study measured PTSD, appetitive aggression, and closeness with combatants in the intervention and control groups. The intervention group was selected to receive FORNET, as described in the previous paragraph, in addition to the standard reintegration programming that all ex-combatants were offered. The control group did not receive FORNET but they did receive the standard reintegration program. Baseline and follow-up measures were recorded for both groups. The team found that the intervention group experienced a decline in PTSD symptoms at follow-up compared to the control group, who experienced a non-significant increase in PTSD symptoms

(Hermenau et al., 2013). Both groups experienced a decrease in appetitive aggression symptoms from baseline to follow-up. It is likely that there was not a significant difference in scores between the intervention and control group for the appetitive aggression measure because both groups were in the reintegration program that covered topics related to appetitive aggression (Hermenau et al., 2013). Finally, there was a significant difference between the intervention and control groups in the extent to which they associated with current combatants. The intervention group reported feeling significantly less connected to current combatants compared to the control group at follow-up (Hermenau et al., 2013,).

Overall, FORNET implemented with ex-combatants and child soldiers has benefits over standard reintegration programming and over traditional NET. The main difference between NET and FORNET is that FORNET allows ex-combatants to reconcile with violence they perpetrated in addition to violence that they were a victim of. NET is solely focused on the processing of traumatic events, not perpetration (Hermenau et al., 2013). As noted in the Peru case study, many ex-combatants have feelings of guilt and shame around violence they perpetrated but do not have a support group to talk with about it. FORNET provides the space to process and come to terms with acts of violence. It also allows an opportunity for ex-combatants to share emotions in a space where others can be empathetic and nonjudgmental. This is important for ex-combatants, who are not easily accepted back into their home communities post-conflict.

While the sample size in the Hermenau et al. (2013) study was small, the results are promising, not only in the ability to implement mental health services in post-conflict settings, but also in the effectiveness in decreasing symptoms associated with negative mental health outcomes and aggressive behavior in ex-combatants.

5.0 Conclusion

The end of a civil conflict does not equate to an end to violence. Recent research has shown that the violence in post-conflict environments continues, but it is transferred from the public to the private sphere. Women and children living in post-conflict environments experience above average rates of DFV. This paper specifically explored how untreated trauma in ex-combatants exacerbates perpetration of violence in the home. While this paper focused on untreated trauma as a contributing factor to the rise in DFV post-conflict, the author acknowledges that there are several root causes that enable DFV.

This paper compared and contrasted two countries, Liberia and Peru, as case studies to understand the rise in DFV in post-conflict environments and evaluate how untreated trauma exacerbated DFV perpetration. These countries were chosen because they both experienced several years of civil conflict with horrendous acts of violence committed by the State as well as civilians. Both Peru and Liberia showed increased rates of PTSD and mental health issues post-conflict, but neither country provided widespread mental health services to ex-combatants. Based on the literature, this paper recommends incorporation of FORNET into rehabilitation and reintegration programs. FORNET has been shown to reduce symptoms of PTSD and appetitive aggression and increase feelings of acceptance into the community.

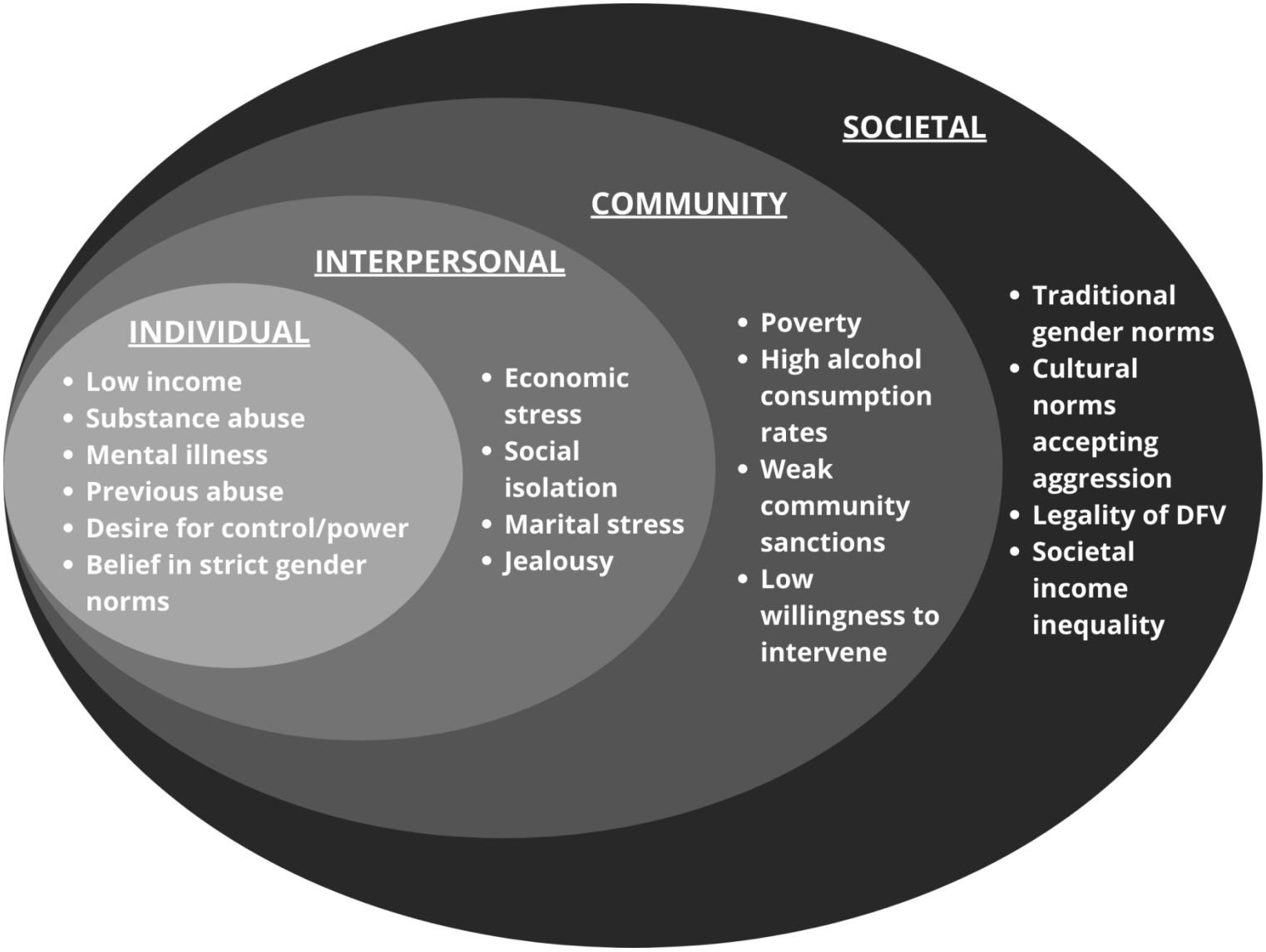
This paper acknowledges a few limitations. First, the author does not speak Spanish and therefore did not have access to all documents in the Peru case study. Even with documents that were translated by Google, there could have been some information that was lost in translation. Another limitation is that only two case studies were analyzed. Had additional case studies been included, there would have been a wider comparison which could have yielded different results.

Additionally, this paper used two theories to help explain untreated PTSD as a contributing factor to the rise in DFV post-conflict. While these theories were chosen because they were the most prevalent across the literature, there are likely additional theories that could be useful in explaining the trend. Another limitation is that data on DFV and mental illness are not collected by the same metrics across countries. Social or cultural stigma also can affect willingness to report victimization or experience of mental illness.

Addressing the trauma and mental illness experienced by ex-combatants is essential to reversing the trend of extreme rates of DFV in post-conflict environments. By following the Cycle of Violence Theory and the Gender Norms theory, it is logical that treating trauma in ex-combatants would reduce their likelihood to perpetrate DFV.

Women and children in post-conflict environments are at the greatest risk of experiencing DFV. Rates of PTSD and mental illness in these environments are higher than the global burden. It is crucial that peacebuilding organizations in post-conflict regions recognize the ongoing threat that women and children face. Funds needs to be directed towards treating the trauma experienced by all to prevent additional violence, however too often, the mental health of ex-combatants is not considered because they are not traditionally viewed as victims. It is necessary for international organization to direct funds used for peacebuilding efforts post-conflict to sufficient mental health services for ex-combatants. While this is only one step of many necessary to decrease rates of DFV in post-conflict environments, it is one that has been critically lacking. The implementation of VAW programs and laws is not enough if we ignore the people who are perpetrating the violence.

Appendix A Social Ecological Model DFV Perpetration



Appendix A Figure 1

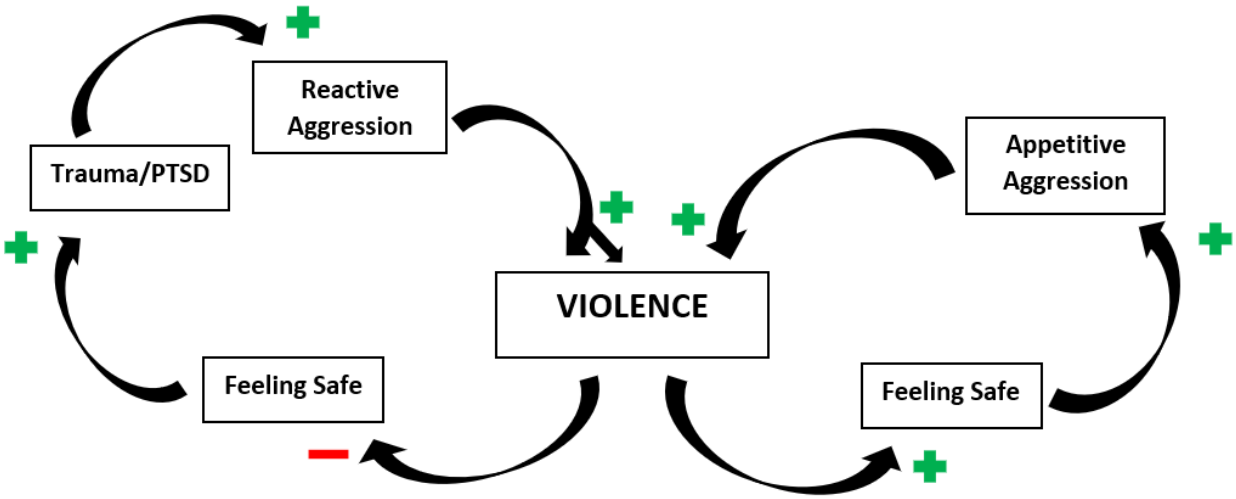
Appendix A Figure 1 is a graphic of the social ecological model of root causes of DFV perpetration. The figure describes individual, interpersonal, community, and societal factors that contribute to perpetration of DFV.

Appendix B Domestic Family Violence Post-Conflict

Appendix B Figure 1

Appendix B Figure 1 was taken from a Mattina (2017) study that compared rates of DFV across Africa based on whether or not they had experienced armed conlifct. The figure shows that in countries with armed conflict, a greater percentage of women experience DFV compared to women in countries without armed conflict.

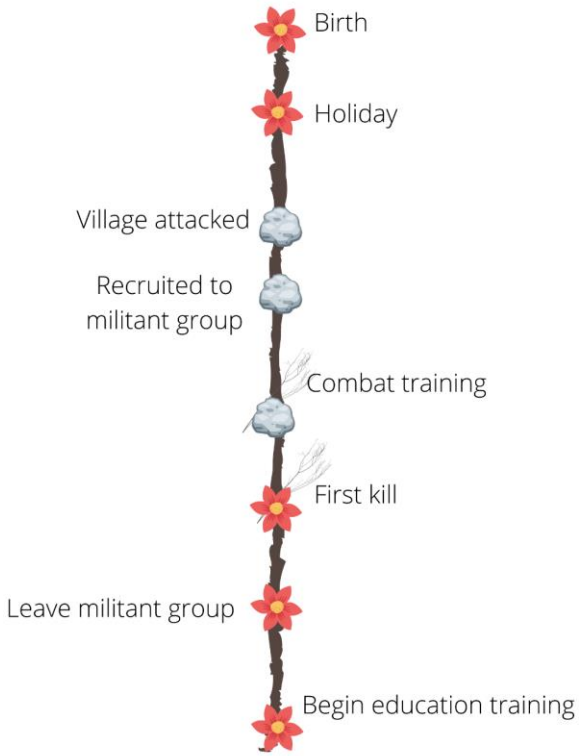
Appendix C Bi-Cycle of Aggression



Appendix C Figure 1

The figure above shows the reactive aggression cycle of violence on the left and the appetitive aggression cycle of violence on the right. After years of exposure to violence and untreated PTSD, reactive aggression and develop into appetitive aggression. The main difference between the two cycles is that with reactive aggression, the individual commits the acts of violence because they feel unsafe. Eventually, with appetitive aggression, the individual begins to feel safe and positively reinforced by acting with violence.

Appendix D FORNET Therapy



Appendix D Figure 1

This image is an example of what a chronological list might look like for ex-combatants participating in FORNET. The stone symbolize traumatic events, flowers signify happy events, and sticks symbolize violence. The overlap of stones with sticks shows instances of violent that were traumatic, likely instances of reactive aggression. On the other hand, flowers with sticks shows instances of violence that were also considered happy, likely appetitive aggression. The therapist can work with the ex-combatant to understand these complicated emotions.

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